ESARVHP
New Hampshire Emergency System for Advance Registration of Volunteer Healthcare Professionals

Allied Health Registration

PLEASE PRINT CLEARLY

Information in RED is REQUIRED.

1. YOUR LICENSE INFORMATION EXACTLY as it appears on your professional license.

First Name _____

Middle Name _____

Last Name _____ Suffix_____

Allied Health License Type: ❑ Athletic Trainers ❑ Occupational Therapist ❑ Occupational Therapist Assistant

❑ Physical Therapist ❑ Physical Therapist Assistant ❑ Recreational Therapist ❑ Speech Language Pathologist

Note: Respiratory Therapists should fill out the Respiratory Therapist Registration form.

License # _____ State Issuing License_____Exp. Date (mm/dd/yyyy)_____

2. CONTACT INFORMATION

Mailing Address _____

City_____State/Zip_____Country_____

Primary Phone _____ Alternate Phone_____

Email Address _____

3. CONSENTS AND PLEDGES

Do you consent to NH collecting, using and maintaining your personal information? ❑ YES ❑ NO

Do you pledge the information you have provided is correct? ❑ YES ❑ NO

Do you consent to allow the State of NH to perform a background check on you? ❑ YES ❑ NO

4. DEPLOYMENT PREFERENCES

Are you willing to work under the auspices of the Federal Government during a declared national public health emergency?
❑ YES ❑ NO

5. EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Emergency Contact Relationship ❑ Spouse ❑ Co-worker ❑ Relative ❑ Friend ❑ Other

Emergency Contact Home Phone _____ Work Phone _____

Email Address _____

6. FOREIGN LANGUAGE/SIGNING SKILLS

Language(s) other than English you speak, read and/or write, or sign _____

_____

Language Fluency ❑ Basic ❑ Conversational ❑ Fluent

American Sign Language Fluency ❑ Basic ❑ Conversational ❑ Fluent

7. DISASTER TRAINING

Type of specialized disaster training received _____

Date completed specialized disaster training (mm/dd/yyyy) _____

Training Institution that offered disaster training _____

Date specialized disaster training certification expires, if any (mm/dd/yyyy) _____

8. SPECIALIZED TRAINING YOU HAVE HAD

❑ ACLS ❑ ADLS ❑ BCLS/CPR ❑ BDLS ❑ CCRN ❑ CEN ❑ EMT ❑ EMT: B / I / P

❑ ENPC ❑ First Aid ❑ HAZ-MAT Decon ❑ HEICS ❑ ICS #_____ ❑ NIMS

❑ PALS ❑ Red Cross DSHR #_____ ❑ TNCC ❑ Wilderness First Responder

❑ Military Training (specify) _____

_____

_____

❑ Other Training (specify) _____

_____

_____

9. OTHER VOLUNTEER ORGANIZATIONS YOU BELONG TO

❑ American Red Cross

❑ Civil Air Patrol

❑ Community Emergency Response Team

❑ Disaster Behavioral Health Response Team

❑ Disaster Medical Assistance

❑ Medical Response Corps

❑ Military Reserve

❑ National Nurse Response Team

❑ NH Public Health Network

❑ NH Strike Team

❑ State Citizens Corps Council

❑ Other (specify) _____

10. HOSPITAL Required to assign ESAR-VHP credential level allowing you to work in a hospital.

Name of hospital where you primarily practice _____

Hospital City, State _____

What specialty do you practice in this hospital? _____

Information in RED is REQUIRED. PAGE 4

11. CLINICALLY ACTIVE Required to assign ESAR-VHP credential level if not currently practicing in a hospital setting.
* Where you practice in an outpatient or other non-hospital setting

Clinical Supervisor's Name _____

Clinical Supervisor's Email _____

Clinical Supervisor's Phone (eg: 5555555555) _____

Facility Name* _____

Facility City, State* _____

PRINT & MAIL ALL PAGES OF THIS FORM TO:

Curtis Metzger
Hospital Preparedness, Medical Reserve Corps, & ESAR-VHP Coordinator
NH HOMELAND SECURITY & EMERGENCY MANAGEMENT
33 Hazen Drive
Concord, NH 03305

THANK YOU FOR YOUR WILLINGNESS TO VOLUNTEER!